		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036053

Facility Name: Care Center of Abingdon

Address: 2000 West Martin (Number) Abingdon (City) 61410 (Zip Code)

County: Knox

Telephone Number: (309) 343-4556 **Fax #** (309) 343-0981

IDPA ID Number: 37-1184958001

Date of Initial License for Current Owners: 03/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ron Wilson **Telephone Number:** (309) 343-1550

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Ron Wilson
(Title) Chief Financial Officer

Paid Preparer
(Signed) See Attached Indpendent Accountant's Report (Date)
(Print Name and Title) McGladrey & Pullen, LLP, 117 East Main Street, Suite 210
(Firm Name & Address) P.O. Box 1070, Galesburg, IL 61401
(Telephone) (309)342-1175 Fax # (309)342-7816

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 2/19/04

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	88	Skilled (SNF)	82	30,228	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	88	TOTALS	82	30,228	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,951	2,777	1,443	8,171	8
9	SNF/PED					9
10	ICF	7,901	2,517		10,418	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,852	5,294	1,443	18,589	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.50%

D. How many bed-hold days during this year were paid by Public Aid?
34 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/07/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 88 and days of care provided 1,443

Medicare Intermediary Administar Federal Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	110,856	13,292	7,200	131,348		131,348		131,348			1
2	Food Purchase		112,647		112,647		112,647	(4,205)	108,442			2
3	Housekeeping	49,986	15,610		65,596		65,596		65,596			3
4	Laundry	32,886	7,220		40,106		40,106		40,106			4
5	Heat and Other Utilities			76,471	76,471		76,471	164	76,635			5
6	Maintenance	24,726	7,323	27,286	59,335		59,335	343	59,678			6
7	Other (specify):*											7
8	**TOTAL General Services**	218,454	156,092	110,957	485,503		485,503	(3,698)	481,805			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	756,888	73,699	2,527	833,114		833,114		833,114			10
10a	Therapy			57,162	57,162		57,162		57,162			10a
11	Activities	28,219	2,819	720	31,758		31,758	(1,473)	30,285			11
12	Social Services	22,317		360	22,677		22,677		22,677			12
13	Nurse Aide Training											13
14	Program Transportation			1,143	1,143	552	1,695		1,695			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	807,424	76,518	73,912	957,854	552	958,406	(1,473)	956,933			16
	C. General Administration											
17	Administrative	49,967			49,967		49,967	39,271	89,238			17
18	Directors Fees											18
19	Professional Services			85,315	85,315		85,315	(64,061)	21,254			19
20	Dues, Fees, Subscriptions & Promotions			17,266	17,266		17,266	(10,986)	6,280			20
21	Clerical & General Office Expenses	17,219	13,616	29,118	59,953		59,953	3,699	63,652			21
22	Employee Benefits & Payroll Taxes			288,577	288,577		288,577	8,671	297,248			22
23	Inservice Training & Education											23
24	Travel and Seminar			214	214		214	4,724	4,938			24
25	Other Admin. Staff Transportation			1,103	1,103	(552)	551		551			25
26	Insurance-Prop.Liab.Malpractice			42,729	42,729		42,729	31	42,760			26
27	Other (specify):* Attached Sch VI			2,755	2,755		2,755	(2,755)				27
28	**TOTAL General Administration**	67,186	13,616	467,077	547,879	(552)	547,327	(21,406)	525,921			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,093,064	246,226	651,946	1,991,236		1,991,236	(26,577)	1,964,659			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Care Center of Abingdon #0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			20,478	20,478		20,478	64,046	84,524			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,153	24,153		24,153	67,369	91,522			32
33	Real Estate Taxes			43,071	43,071		43,071	152	43,223			33
34	Rent-Facility & Grounds			275,616	275,616		275,616	(273,739)	1,877			34
35	Rent-Equipment & Vehicles			30	30		30	225	255			35
36	Other (specify):*											36
37	**TOTAL Ownership**			363,348	363,348		363,348	(141,947)	221,401			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			5,773	5,773		5,773		5,773			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			45,342	45,342		45,342		45,342			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			51,115	51,115		51,115		51,115			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,093,064	246,226	1,066,409	2,405,699		2,405,699	(168,524)	2,237,175			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,976)	V-2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,555	V-30		9
10	Interest and Other Investment Income	(38)	V-32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(229)	V-2		13
14	Non-Care Related Interest	(24,153)	V-32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,025)	V-27		24
25	Fund Raising, Advertising and Promotional	(10,924)	V-20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(63)	V-20		28
29	Other-Attach Schedule See Att Sch VII	(3,203)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (39,056)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(129,468)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (129,468)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (168,524)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Care Center of Abingdon

ID# 0036053

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(4,290)	0	0	0	0	0	0	0	0	0	(4,290)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(4,290)	0	0	0	0	0	0	0	0	0	(4,290)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	(4,290)	0	0	0	0	0	0	0	0	0	(4,290)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(125,178)	0	0	0	0	0	0	0	0	0	(125,178)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(125,178)	0	0	0	0	0	0	0	0	0	(125,178)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	(129,468)	0	0	0	0	0	0	0	0	0	(129,468)	45

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illini Manors, Inc						
(100% owned by Don Fike)	100	See Attached Schedule I		RFMS, Inc.	Galesburg	Admin Services
				Donald E. Fike	Galesburg	Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	34	Facility Rent	275,616	Donald E. Fike	None	150,438	(125,178)	2
3	V								3
4	V								4
5	V	19	Administrative Services	66,000	RFMS, Inc.	None	61,710	(4,290)	5
6	V				(100% Don Fike owned)				6
7	V								7
8	V				See Attached Schedules III and IV				8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 341,616			$ 212,148	$ * (129,468)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Don Fike	President	Management	100.00	See Att Sch III	>40	100.00	Salary	$ 7,398	17-7	1
2								Benefits	398	22-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,796		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2	Bank One, Illinois		X	Mortgage on Facility	Varies pd Qtr	12/16/99	1,519,200	1,129,200	12/1/14	7.7200	91,559	2
3												3
4	Interest Income Adjustment			From page 5, line 10							(38)	4
5												5
	Working Capital											
6												6
7												7
8	Home Office allocation Adj			See Attached Schedule III							1	8
9	TOTAL Facility Related						$ 1,519,200	$ 1,129,200			$ 91,522	9
	B. Non-Facility Related*											
10												10
11	Don Fike (owner)	X		Working capital		6/1/2000	405,000	836,000	1/1/2005		16,540	11
12	RFMS, Inc. (100% Don Fike)	X		Working capital		5/1/2002	75,000	560,000	1/1/2005		7,613	12
13	Non-allowable interest										(24,153)	13
14	TOTAL Non-Facility Related						$ 480,000	$ 1,396,000			$	14
15	TOTALS (line 9+line14)						$ 1,999,200	$ 2,525,200			$ 91,522	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	52,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	47,210	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,790)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	50,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$	3,133	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 5,272 For 2003 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	(5,272)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	43,071	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	43,373	8
	2000	45,525	9
	2001	47,762	10
	2002	50,021	11
	2003	47,210	12

Real Estate tax accrual is based on estimated tax expense The lessee, by terms of the lease agreement, is required to pay the applicable real estate taxes.

Line 5 expenses relate to professional fees to appeal real estate tax assessment.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Care Center of Abingdon COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0036053

CONTACT PERSON REGARDING THIS REPORT Ron Wilson

TELEPHONE (309) 343-1550 FAX #: (309) 343-2857

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-32-455-017	Don & Marie Fike	$ 47,210.00	$ 47,210.00
2.		Sec 32, Twp 10, Range 1	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 47,210.00	$ 47,210.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,366 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	5.85 acres	1986	$ 80,995	1
2					2
3	TOTALS			$ 80,995	3

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74			1986	$ 999,667	$ 39,987	25	$ 39,987	$	$ 765,751	4
5	14			1993	558,113	15,896	39	13,423	(2,473)	130,724	5
6											6
7											7
8											8
	Improvement Type**										
9	Total improvements by year constructed:										9
10	1987			1987	86,942	2,665	5 to 19	2,665		83,856	10
11	1988			1988	8,021		15			8,021	11
12	1989			1989	6,417	169	10 to 31	169		3,741	12
13	1990			1990	40,719	1,293	5 to 20	1,649	356	30,849	13
14	1991			1991	1,975		15	132	132	1,767	14
15	1992			1992	7,058	224	10		(224)	7,058	15
16	1993			1993	78,808	2,021	7 to 20	3,768	1,747	46,462	16
17	1994			1994	3,355	198	15 to 40	186	(12)	1,970	17
18	1995			1995	31,300	1,848	20	1,565	(283)	14,737	18
19	1996			1996	55,351	2,470	20	2,768	298	23,078	19
20	1999			1999	28,389	901	10	2,839	1,938	16,324	20
21											21
22	Detailed improvements for years 2001-2004:										22
23	Patio/walkway			2002	3,596	240	15	240		620	23
24	Fire Doors			2002	13,715	914	15	914		2,361	24
25	Patio fence			2002	2,048	137	8	256	119	640	25
26	Door locks			2002	3,739	249	15	249		602	26
27	Vinyl flooring			2002	4,130	413	10	413		964	27
28	Door locks			2003	1,274	85	15	85		163	28
29	Drywall			2004	14,048	585	15	780	195	780	29
30	Lightning surge system			2004	27,000	900	15	900		900	30
31	Fire dampers			2004	8,414	280	10	421	141	421	31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,984,079	$ 71,475		$ 73,409	$ 1,934	$ 1,141,789	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 460,425	$ 4,828	$ 8,079	$ 3,251	5 to 15	$ 434,000	71
72	Current Year Purchases	56,161	3,054	2,424	(630)	5 to 12	2,424	72
73	Fully Depreciated Assets							73
74	Indirect Costs Allocated (see Attached Schedule III)		612	612				74
75	TOTALS	$ 516,586	$ 8,494	$ 11,115	$ 2,621		$ 436,424	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	89 Ford Aerostar	1993	$ 4,298	$	$	$	5	$ 4,298	76
77										77
78										78
79										79
80	TOTALS			$ 4,298	$	$	$		$ 4,298	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,585,958	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 79,969	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 84,524	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,555	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,582,511	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Donald E. Fike

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ See Attached			3
4	Additions				Schedule IV-			4
5					Related Party			5
6					Lease			6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 90,052	$ 376,829	1
2	Cash-Patient Deposits	1,963	1,963	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,925)	666,070	1,652,288	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		1,022,236	8
9	Other(specify): See Att Sch VIII		17,744	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 758,085	$ 3,071,060	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		33,333	13
14	Buildings, at Historical Cost		1,619,596	14
15	Leasehold Improvements, at Historical Cost	324,920	573,994	15
16	Equipment, at Historical Cost	310,647	1,239,016	16
17	Accumulated Depreciation (book methods)	(350,460)	(2,331,506)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 285,107	$ 1,134,433	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,043,192	$ 4,205,493	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 75,226	$ 131,051	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,963	10,963	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	107,777	235,391	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,707	3,707	31
32	Accrued Real Estate Taxes(Sch.IX-B)	50,000	57,380	32
33	Accrued Interest Payable	53,198	60,463	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Interdivision Payable	1,396,000	1,396,000	36
37	Other current Liabilities			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,696,871	$ 1,894,955	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,129,200	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Security Deposits			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,129,200	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,696,871	$ 3,024,155	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (653,679)	$ 1,181,338	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,043,192	$ 4,205,493	48

*(See instructions.)

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (378,459)	1
2	Restatements (describe):		2
3	**Year end adjustments made subsequent to the filing of the**		3
4	**prior year's Medicaid cost report (see Att Sch IX)**	(41,060)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (419,519)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(234,160)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (234,160)	17
	B. Transfers (Itemize):		
18	**Transfers**		18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (653,679)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,144,811	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,144,811	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	12,926	6
7	Oxygen	3,390	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 16,316	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,303	13
14	Non-Patient Meals	3,976	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,279	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	38	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 38	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Activity Fund	1,473	28
28a	Durable medical equipment	3,622	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,095	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,171,539	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	485,503	31
32	Health Care	957,854	32
33	General Administration	547,879	33
	B. Capital Expense		
34	Ownership	363,348	34
	C. Ancillary Expense		
35	Special Cost Centers	5,773	35
36	Provider Participation Fee	45,342	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,405,699	40
41	**Income before Income Taxes (line 30 minus line 40)****	(234,160)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (234,160)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,768	1,901	$ 38,029	$ 20.00	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	8,161	8,776	135,319	15.42	3
4	Licensed Practical Nurses	7,125	7,662	91,173	11.90	4
5	Nurse Aides & Orderlies	49,032	52,723	442,869	8.40	5
6	Nurse Aide Trainees					6
7	Licensed Therapist			0		7
8	Rehab/Therapy Aides			0		8
9	Activity Director	1,658	1,783	18,794	10.54	9
10	Activity Assistants	1,189	1,279	9,425	7.37	10
11	Social Service Workers	1,730	1,860	22,317	12.00	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,746	14,781	110,856	7.50	15
16	Dishwashers					16
17	Maintenance Workers	2,744	2,951	24,726	8.38	17
18	Housekeepers	5,998	6,449	49,986	7.75	18
19	Laundry	4,478	4,815	32,886	6.83	19
20	Administrator	2,057	2,212	44,249	20.00	20
21	Assistant Administrator	626	673	5,718	8.50	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,779	1,913	17,219	9.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	17	20	198	9.90	31
32	Other Health Care(specify)	4,234	4,552	49,300	10.83	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	106,342	114,350	$ 1,093,064 *	$ 9.56	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	***	$ 7,200	1-3	35
36	Medical Director	***	12,000	9-3	36
37	Medical Records Consultant	***	0	10-3	37
38	Nurse Consultant	***	0	10-3	38
39	Pharmacist Consultant	***	2,527	10-3	39
40	Physical Therapy Consultant	***	30,418	10a-3	40
41	Occupational Therapy Consultant	***	23,714	10a-3	41
42	Respiratory Therapy Consultant	***	0	10a-3	42
43	Speech Therapy Consultant	***	3,030	10a-3	43
44	Activity Consultant	***	0	11-3	44
45	Social Service Consultant	***	360	12-3	45
46	Other(specify) Dental Consultant	***	0	10-3	46
47					47
48	*** Monthly Fee				48
49	TOTAL (lines 35 - 48)		$ 79,249		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Darlyne Shryck	Administrator	None	$ 44,249
Alice Becker	Asst. Admin.	None	5,718
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 49,967

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
RFMS, Inc.	Administrative Services	$ 66,000
McGladrey & Pullen, LLP	Accounting Services	15,805
RSM McGladrey, Inc.	Tax Services	3,510
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 85,315

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 43,254
Unemployment Compensation Insurance	26,404
FICA Taxes	82,832
Employee Health Insurance	124,996
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Plan Contributions	7,876
Other Employee Benefits	2,719
Employee Appreciation	496
Indirect Costs- See Attached Sch III	8,671
TOTAL (agree to Schedule V, line 22, col.8)	$ 297,248

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	1,219
Health Care Worker Background Check	
(Indicate # of checks performed 87)	1,221
Subscriptions	353
IHCA Dues	2,870
Advertising- Promotion	10,924
Other Licenses and Fees	216
Advertising - Yellow Pages	63
Indirect Costs - See Att Sch III	1
Less: Public Relations Expense	( )
Non-allowable advertising	(10,924)
Yellow page advertising	(63)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 6,280

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	
Staff use of personal vehicle on facility	
business and meals (under $250 per	
travel voucher)	0
Seminar Expense	214
Less: Non-allowable out-of-state travel	
Indirect Costs- See Att Sch III	4,724
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,938

**See instructions.

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Care Center of Abingdon # 0036053 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Page 21, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **9 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,037** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **45,342**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,976**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.